



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Presumptive Eligibility

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Presumptive Eligibility

Note: For updates to the information in this module, see [IHCP Banner Pages and Bulletins](#) at [in.gov/medicaid/providers](#).

Introduction

The Presumptive Eligibility (PE) process allows qualified providers (QPs) to make determinations for certain eligibility groups to receive temporary health coverage under the Indiana Health Coverage Programs (IHCP) until official IHCP eligibility is determined. IHCP providers, including organizations and individual practitioners within designated specialties, can become certified as QPs.

During this period of PE, the individual will be able to receive coverage for treatment from the QP as well as from other IHCP-enrolled providers. PE coverage is different from “pending” Medicaid; under PE, providers are eligible for reimbursement at the time services are rendered, versus waiting for Medicaid coverage (including retroactive coverage, if applicable).

The individual must complete an *Indiana Application for Health Coverage* during the PE period to gain continued coverage through the IHCP. If an individual does not complete this application, he or she will lose coverage after the PE period ends. An individual is allowed only one PE coverage period per rolling 12-month period or per pregnancy.

Presumptive Eligibility Process Overview

An individual seeking coverage works with a QP at the point of service to complete an electronic PE application. The individual relays the necessary information, and the QP enters the information online via the IHCP Provider Healthcare Portal (Portal), as described in the [Completing the Presumptive Eligibility Member Application](#) section of this module.

Note: Applicant responses are self-attested; therefore, QPs are not permitted to ask for supporting documentation to verify the applicant’s eligibility. An individual can apply for PE for all members in his or her family, regardless of need for services at the time of application.

Questions include identifying information, family size, and household income. The Portal provides a real-time response on whether the individual is eligible for PE coverage based on responses provided during the application process.

After presumptive eligibility is determined, the QP informs the individual of PE approval or denial. Approved individuals receive temporary coverage under one of the following benefit plans, depending on the information provided:

- Presumptive Eligibility – Package A Standard Plan
- Presumptive Eligibility – Adult (PE Adult)
- Presumptive Eligibility for Pregnant Women (PEPW)
- Presumptive Eligibility Family Planning Services Only
- Medicaid Inpatient Hospital Services Only (PE for Inmates)

These benefit plans provide coverage for designated services during the approved individual's PE period. Beginning and end dates for the PE period are as follows:

- The PE coverage period **begins** on the date the QP determines an individual is presumptively eligible for coverage through the IHCP.
- The PE coverage period **ends** when one of the following circumstances occurs:
 - The member does not submit an *Indiana Application for Health Coverage* within the allotted time frame. A completed *Indiana Application for Health Coverage* must be pending with the FSSA by the end of the month following the month in which PE coverage began.
 - The FSSA officially determines the member to be ineligible for coverage under an IHCP program. Eligibility for PE ends on the day after DXC receives denial of eligibility information from the FSSA.
 - The FSSA officially determines the member to be eligible for coverage under an IHCP program. PE coverage will end prior to the IHCP program start date with no gap in coverage.

Presumptive Eligibility Team

Several entities work together to ensure that the PE process works properly. The responsibilities of each entity are described in the following sections.

Qualified Providers

QPs use an easy, user-friendly online tool to complete the PE member application. PE member enrollment services are performed on a voluntary basis. Although QP functions are not reimbursable, QPs are reimbursed for covered healthcare services provided to individuals determined to be presumptively eligible.

QP responsibilities include the following:

- Verify whether individuals have current IHCP coverage by using one of the Eligibility Verification System (EVS) options:
 - [Provider Healthcare Portal](#), accessible from the home page at in.gov/medicaid/providers
 - Interactive Voice Response (IVR) system at 1-800-457-4584
 - 270/271 electronic transactions
- Enroll qualifying individuals in the PE process as follows:
 - 24 hours a day, 7 days a week, for acute care hospitals and psychiatric hospitals
 - During regular business hours for all other QPs
- Make presumptive eligibility determinations consistent with State policies and procedures.
- Guide individuals on the requirements to complete and submit the *Indiana Application for Health Coverage* by the end of the month following the month that the PE determination was made (see the [Completing the Presumptive Eligibility Member Application](#) section).

For State and federal requirements for QPs, including which IHCP providers are eligible to become QPs, see the [Qualified Provider Requirements](#) section.

Note: Some provider specialties can be certified as PEPW QPs only, meaning that they are limited to making PE determinations only for pregnant women. PEPW enables eligible women to receive prenatal care earlier in their pregnancies. Pregnant women found to be presumptively eligible have coverage for their first prenatal visit to a QP. Enrolling as a QP is an important step providers can take to provide prenatal care and improve birth outcomes.

Indiana Navigators and Application Organizations

QPs may apply to be authorized representatives or Application Organizations (AOs), but they are not required to do so. QP staff members helping individuals complete the *Indiana Application for Health Coverage* also need to be certified as Indiana Navigators or designated as authorized representatives. Only in those roles may the QP staff assist the PE applicant with his or her *Indiana Application for Health Coverage*. All navigators must receive state training, undergo annual state certification, and meet state-based performance standards monitored by the Indiana Department of Insurance (IDOI).

Some QPs may choose to contract with eligibility assistance companies for completing and submitting the *Indiana Application for Health Coverage*. If the organization contracts with an eligibility assistance company, that company should have staff that are certified as Indiana Navigators or designated as authorized representatives working with PE participants to complete the *Indiana Application for Health Coverage*.

For more information about the Indiana Navigators and AOs, see the [Indiana Navigators](https://www.in.gov/idoi) page at [in.gov/idoi](https://www.in.gov/idoi).

DXC Technology

As the contracted fiscal agent for the IHCP, DXC is responsible for the following:

- Maintain and provide training for the Portal.
- Enroll new QPs and maintain a list of QPs certified for PE or PEPW.
- Post enrolled QPs in the [IHCP Provider Locator](https://www.in.gov/medicaid/providers) feature, accessible from the home page [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers).
- Provide PE training materials to QPs.
- Answer any questions QPs may have regarding the PE process.
- Assign PE identification numbers (PE IDs).
- Maintain coverage information about all eligible members through the EVS options: the Portal, IVR system, and 270/271 electronic transactions.
- Handle prior authorization requests (when required) for nonpharmacy services provided to PE members.
- Process all claims for nonpharmacy services provided to PE members.
- Update the Core Medicaid Management Information System (*CoreMMIS*) with IHCP eligibility information received from the FSSA Division of Family Resources (DFR).

FFS pharmacy claims and related prior authorization requests are handled by the contracted pharmacy benefit manager, OptumRx. For contact information, see the [IHCP Quick Reference Guide](https://www.in.gov/medicaid/providers) at [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers).

FSSA Division of Family Resources

DFR responsibilities include the following:

- Accept and process any *Indiana Application for Health Coverage* received from a QP or an individual.
- Convey official IHCP eligibility determinations to DXC and to the PE member.
- Assign the IHCP Member ID (also known as RID) when eligibility is officially approved.

Qualified Provider Requirements

Table 1 lists the IHCP providers that can apply to become certified as QPs for the PE process. As indicated in the table, certain provider specialties are limited in the types of PE determinations they can perform.

Table 1 – IHCP Providers Eligible to Become QPs for the PE Process

Eligible Provider	Provider Type, Specialty	PE Determinations
Acute care hospital	Type 01, specialty 010	All
Freestanding psychiatric hospital	Type 01, specialty 011	All
Family practitioner	Type 31, specialty 316	Pregnant women only
General practitioner	Type 31, specialty 318	Pregnant women only
Obstetrician/gynecologist	Type 31, specialty 328	Pregnant women only
General internist	Type 31, specialty 344	Pregnant women only
General pediatrician	Type 31, specialty 345	Pregnant women only
Federally qualified health center (FQHC)	Type 08, specialty 080	All*
Rural health clinic (RHC)	Type 08, specialty 081	All*
Medical clinic	Type 08, specialty 082	Pregnant women only
Family planning clinic	Type 08, specialty 083	Pregnant women only
Nurse practitioner (other, for example, clinical nurse specialist)	Type 09, specialty 093	Pregnant women only
Certified nurse midwife	Type 09, specialty 095	Pregnant women only
Community mental health center (CMHC)	Type 11, specialty 111	All*
County health department	Type 13, specialty 130	All*
<i>*Note: FQHCs, RHCs, CMHCs, and county health departments have the option to be certified as PEPW QPs only, if they choose. Unless these providers are certified for the full PE process, they are limited to making PE determinations for pregnant women only.</i>		

State Requirements

The State requires that all QPs meet the following requirements:

- Complete and submit the eligibility attestations (for PE or PEPW certification) through the QP enrollment process on the Portal as follows:
 - For PE:
 - Affirm that the organization understands and will abide by any published guidance regarding the performance of PE activities.
 - Affirm that the organization will not knowingly or intentionally misrepresent client information to inappropriately gain presumptive eligibility.
 - Affirm the understanding that all PE enrollment activities undertaken by the organization must be performed by an employee or organization's designee.
 - For PEPW:
 - Affirm that the provider is able to provide outpatient hospital, rural health clinic, or clinic services as defined in sections 1905(a)(2)(A) or (B), 1905(a)(9), and 1905(l)(1) of the *Social Securities Act*.
 - Affirm that the provider is able to verify pregnancy via a professionally administered pregnancy test.
 - Affirm that the provider has internet, printer, telephone, and fax access.

- Participate in PE QP training, including training in the Portal PE process.
- Enroll qualifying individuals in the PE process as follows:
 - 24 hours a day, 7 days a week, for acute care hospitals and psychiatric hospitals
 - During regular business hours for all other QPs
- Help individuals complete and submit a full *Indiana Application for Health Coverage*.

In addition, the State requires all QPs to meet performance standards determined by the State and documented in *Indiana Administrative Code (IAC)*.

Federal Requirements

In addition to State requirements, federal requirements exist for certain QPs.

For PE QPs that are acute care hospitals or psychiatric hospitals, federal regulations require that the hospital do the following:

- Participate as a provider under the IHCP State Plan or under a demonstration project as described in *Section 1115* of the *Social Security Act*.
- Notify the IHCP of its intention to make PE determinations.
- Agree to make PE determinations consistent with State policies and procedures.

Federal Medicaid regulations require that a PEPW QP must be enrolled as an IHCP Medicaid provider.

Enrolling as a Qualified Provider

IHCP-enrolled providers meeting PE process requirements are encouraged to enroll as QPs as follows:

1. Log in to the [Provider Healthcare Portal](#), accessible from the home page at [in.gov/medicaid/providers](#).

Providers must first register for the Portal, as described in the [Provider Healthcare Portal](#) module.

2. From the *My Home* page, click the **Provider Maintenance** link.

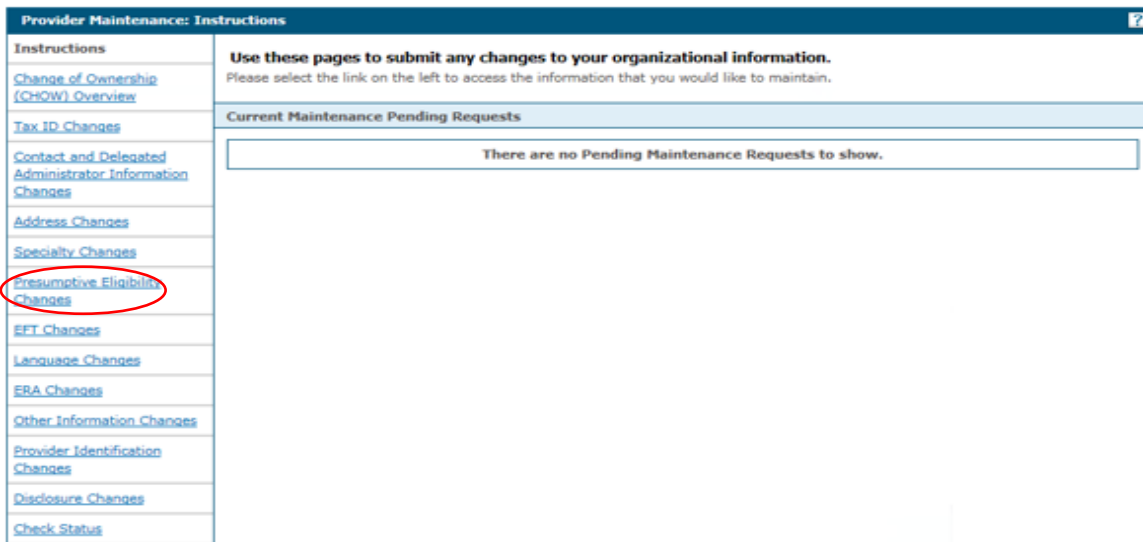
Figure 1 – Provider Maintenance Link on the Portal's *My Home* Page



- On the left side of the *Provider Maintenance Instructions* page, click the **Presumptive Eligibility Changes** link.

Note: This option appears only for provider specialties that are eligible to become QPs. See [Table 1](#) for details.

Figure 2 – Presumptive Eligibility Changes Link on the *Provider Maintenance: Instructions* Page



- Answer the questions and complete all the fields indicated in the Presumptive Eligibility or Presumptive Eligibility for Pregnant Women section of the *Provider Maintenance: Presumptive Eligibility* page.

Note: The options shown vary by provider specialty. Certain provider specialties can become certified as QPs for PEPW only, limiting their PE determinations to pregnant women only. These providers will see only the Presumptive Eligibility for Pregnant Women section.

Some provider specialties will see both sections, as shown in Figure 3. These providers can choose whether to become QPs for all PE aid categories, or to become certified for PEPW only. See [Table 1](#) for details.

Figure 3 – Provider Maintenance: Presumptive Eligibility Page

Provider Maintenance: Presumptive Eligibility	
<p>You are initiating a change request. Complete the desired changes for fields in each section and click the "Submit" button to submit this change request.</p> <p>* Indicates a required field.</p>	
<h3>Presumptive Eligibility for Pregnant Women</h3> <p>Presumptive Eligibility for Pregnant Women (PEPW) is a limited period of time during which a pregnant woman, who has been determined to be presumptively eligible by a 'Qualified Provider' (QP), will be covered for ambulatory prenatal services.</p> <p>Note: Inpatient care, delivery services and services unrelated to the pregnancy or birth outcome are not covered under PEPW.</p> <p>The PEPW patient enrollment process will generate documents in Adobe Acrobat Portable Document Format (PDF). To view or print these documents, you must have the free Adobe Acrobat Reader installed. You can get the latest version of Adobe Acrobat Reader from the Web Tool Kit.</p> <p>You have been identified as a potential Pre-Qualified Provider. Please answer the following questions if you would like to begin the qualification process.</p> <p>*Are you able to provide outpatient hospital, rural health clinic, or clinic services as defined in sections 1905(a)(2)(A) or (B), 1905(a)(9), and 1905(1)(1) of the ACT? <input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p>.... Read More</p> <p>*Are you able to verify pregnancy via a professionally administered pregnancy test? <input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p>*Do you have internet, printer, telephone and fax access? <input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p>*Contact Name <input type="text"/> *Contact Email <input type="text"/></p> <p>I would like to terminate my PEPW Qualified Provider status: <input type="checkbox"/></p>	
<h3>Presumptive Eligibility</h3> <p>Presumptive Eligibility (PE) is a limited period of time during which an applicant, who has been determined to be presumptively eligible by a 'Qualified Provider' (QP), will be covered for services applicable to their approved eligibility program.</p> <p>A QP must have a Provider Agreement with the Office of Medicaid Policy and Planning (OMPP).</p> <p>The PE patient enrollment process will generate documents in Adobe Acrobat Portable Document Format (PDF). To view or print these documents, you must have the free Adobe Acrobat Reader installed. You can get the latest version of Adobe Acrobat Reader from the Web Tool Kit.</p> <p>Training must be completed prior to your enrollment being activated. Click here to view PE training materials Indianamedicaid.com.</p> <p>You have been identified as a potential Pre-Qualified Provider. Please answer the following questions if you would like to begin the qualification process.</p> <p>*I affirm that this organization understands and will abide by any published guidance regarding the performance of Presumptive Eligibility activities. <input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p>*I affirm that this organization will not knowingly or intentionally misrepresent client information in order to inappropriately gain presumptive eligibility. <input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p>*I affirm my/our understanding that all PE enrollment activities undertaken by this organization must be performed by an organization's employee or organization's designee. <input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p>*Contact Name <input type="text"/> *Contact Email <input type="text"/></p> <p>I would like to terminate my PE Qualified Provider status: <input type="checkbox"/></p>	
<p align="right"> <input type="button" value="Submit"/> <input type="button" value="Cancel"/> </p>	

Note: The individual responding to the questions must provide his or her name and email address for the Contact Name and Contact Email fields.

5. Click **Submit**.
6. On the *Provider Maintenance: Tracking Information* page, click **Print Preview** to print a copy of the confirmation and then click **Exit**.

Figure 4 – *Provider Maintenance: Tracking Information* Page



If the provider answered “yes” to the questions and entered a contact name and email address, a Provider Relations consultant contacts the prequalified QP within 10 days to schedule a Portal training session. The Provider Relations consultant also provides the QP with a link to the PE process training presentation.

After the training session is completed, the Provider Enrollment Unit will activate the certified QP in CoreMMIS. The QP may then make PE determinations and submit applications under the PE process.

Note: If the provider has not heard from a Provider Relations field consultant within 10 days of submitting the application, the provider should contact his or her Provider Relations field consultant.

Terminating QP Status

Existing QPs can terminate their QP status through the Portal by selecting the appropriate check box to terminate their status on the *Provider Maintenance: Presumptive Eligibility* page in the Portal (see [Figure 3](#)).

Presumptive Eligibility Applicant Requirements

Individuals in the following aid categories are eligible for PE coverage:

- Infants (up to age 1)
- Children (ages 1–18)
- Adults (ages 19–64) without Medicare
- Parents/Caretakers
- Former Foster Care Children
- Pregnant Women
- Family Planning (individuals eligible for the Family Planning Eligibility Program only)

All PE applicants must meet some general requirements as well as requirements specific to their aid category.

*Note: Qualified providers may **not** ask for verification documents when performing PE tasks. Proof of income, pregnancy, residency, citizenship, and any other documents for eligibility verification are not required at the time of application for PE.*

Although verification is not allowed, providers must not enter information they know to be false into the Portal.

General Requirements for All PE Applicants

PE is based on the following criteria that the applicant must meet:

- Be a U.S. citizen, qualified noncitizen, or a qualifying immigrant with one of the following immigration statuses:
 - Lawful permanent resident immigrant living lawfully in the United States for 5 years or longer
 - Refugee
 - Individual granted asylum by immigration office
 - Deportation withheld by order from an immigration judge
 - Amerasian from Vietnam
 - Veteran of U.S. Armed Forces with honorable discharge
 - Other qualified alien
- Be an Indiana resident
 - An Indiana address must be provided on the application.
- Not be a current IHCP member, including a member of HIP*
 - Medical Review Team (MRT) and Preadmission Screening and Resident Review (PASRR) coverage are the only exceptions to this requirement; members with coverage under any other benefit plan are not eligible for PE.
 - Individuals who have recently applied for the IHCP but have not yet received a coverage determination may apply for PE to cover services while an IHCP decision is pending.
- Not be enrolled in the PE process, currently or within time-frame restrictions*
 - Individuals are allowed only one PE coverage period per rolling 12 months or per pregnancy.
- Not be currently incarcerated*
- Not be an adult (age 21–64) admitted to or residing in an institute for mental disease (IMD)
- Meet the income level requirements specific to certain aid categories, as outlined in [Table 2](#)
- Meet any additional requirements specific to certain aid categories, as described in the [Specific Requirements for PE Aid Categories](#) section

**Note: For exceptions specific to inmates, see the [Special Rules Regarding Presumptive Eligibility for Inmates](#) section (applicable for hospital PE QPs [specialties 010 and 011] only).*

Table 2 – Aid Category and Income Limit

Aid Category Description	Income Limit
PE Infants (under 1 year old)	213% federal poverty level (FPL)
PE Children (ages 1–18)	163% FPL
PE Adults (ages 19–64)	138% FPL
PE Parents/Caretakers	Converted modified adjusted gross income (MAGI) equivalent limit
PE Former Foster Care Children	No income requirement
PE Pregnant Women	213% FPL
PE Family Planning	146% FPL
<i>Note: These percentages include an addition of 5 percentage points to roughly estimate the 5% income that will be disregarded from the individual's income. This disregard is based on the applicable income standard if the individual would have otherwise been ineligible when a full application is submitted to the DFR.</i>	

To determine whether the applicant meets the income limit, the QP enters the applicant's family size and family income into the PE application:

- **Family size** is based on the tax household. Family size includes the following individuals:
 - Applicant
 - Applicant's children under age 19 (including unborn children if the applicant is pregnant)
 - Applicant's spouse (if taxes are filed jointly with spouse)
 - Applicant's spouse's children under age 19 (if taxes are filed jointly with spouse)
 - Applicant's parents (biological, adopted, and step), if applicant under age 19 and unmarried
 - Applicant's unmarried siblings (biological, adopted, and step) under age 19, if applicant is under age 19 and unmarried
- **Family income** is based on pretax income (not take-home pay). Family income includes the combined pretax income of the following individuals:
 - Applicant
 - Applicant's spouse (if applicant is married)
 - Applicant's parents (if applicant is under age 19 and unmarried)

Family income includes earned income (such as wages and tips) and unearned income (such as Social Security Disability Insurance payments). It does **not** include the following:

- Child support
- Supplemental Security Income (SSI)
- Veteran's benefits
- Cash contributions
- American Indian or Alaska Native Tribal income

Based on the information entered, the Portal systematically determines whether the applicant meets the income criteria for the appropriate PE aid category, as shown in [Table 2](#). Although PE is systematically determined, QPs can refer to the [Eligibility Guide](#) on the IHCP member website at in.gov/medicaid/members to find actual income guidelines for the eligibility groups. The family income limits are also available in the [IHCP Presumptive Eligibility Standards](#) document at in.gov/medicaid/providers.

Specific Requirements for PE Aid Categories

For the following aid categories, an individual must meet all listed criteria to be eligible.

Infants

- Must be under 1 year of age
- Family income must be less than 213% of the FPL

Children

- Must be between the ages of 1 and 18 years old (up to 19th birthday)
- Family income must be less than 163% of the FPL

Adults

- Must be age 19–64 (up to 65th birthday)
- Cannot have Medicare
- Cannot have a HIP conditional status
- Family income must be less than 138% of the FPL

Parents/Caretakers

- Must live with a person under the age of 18 and must be the individual taking care of the minor
- Must have income less than converted MAGI equivalent limits

Former Foster Care Children

- Must be age 18–25 (up to 26th birthday) if in foster care at age 18 in Indiana; must be age 18–20 (up to 21st birthday) if in foster care at age 18 in an out-of-state foster care
- Must have been in foster care at age 18
- Must have been enrolled in the IHCP at age 18

Pregnant Women

- Must be pregnant, but the pregnancy does not need to be medically verified
- Must have income less than 213% of the FPL

Note: When calculating percentage of FPL, the pregnant woman's unborn child or children should be counted toward family size.

See the [Family Size and Income Examples for Pregnant Applicants](#) section for examples.

Family Planning

- Must not be eligible for any other PE aid category
- Must have income less than 146% the FPL

Family Size and Income Examples for Pregnant Applicants

The following examples are included to assist providers in determining family size and family income for pregnant applicants.

Family Size Examples

The following examples show how family size is determined:

- A. An unmarried, pregnant 19-year-old woman and her 2-year-old adopted child live with the woman's grandparents. The pregnant woman is not tax-dependent on her grandparents.
Family size: Three – The pregnant woman, her unborn child, and her adopted child. Do not count the grandparents.
- B. An unmarried, pregnant 16-year-old woman lives with her mother and four siblings aged 13, 10, 8, and 5. The pregnant woman is tax-dependent on her mother.
Family size: Seven – The pregnant woman, her unborn child, the pregnant woman's mother, and four siblings
- C. A married 39-year-old pregnant woman lives with her spouse and five tax-dependent children ages 20, 19, 16, 15, and 10. The couple files taxes jointly.
Family size: Eight – The pregnant woman, her unborn child, her spouse, and her five dependent children.
- D. An unmarried 19-year-old woman pregnant with twins lives with her father, her stepmother, her father's children ages 16 and 14, her stepmother's child age 13, and her father's adoptive child age 9. The pregnant woman is not tax-dependent on her parents.
Family size: Three – The pregnant woman and her unborn twins. Because the applicant is not under 19 and is not tax-dependent, do not count her parents or her parents' children.
- E. An unmarried pregnant woman lives on her own with her 2-year-old child and her boyfriend. The pregnant woman does not file taxes with her boyfriend.
Family size: Three – The pregnant woman, her unborn child, and her 2-year-old child. Do not count her boyfriend.
- F. A married 17-year-old woman pregnant with twins lives with her spouse and her parents. The pregnant woman files jointly with her husband.
Family size: Four – The pregnant woman, her unborn twins, and her spouse. Do not count her parents.

Family Size and Income Examples

The following examples show how to determine the family income (all earnings amounts are before taxes):

- A. An unmarried 17-year-old pregnant woman is paid \$475 per month from her job and receives an additional \$150 per month cash assistance from her parents. She lives with her grandmother, who receives \$775 per month in Social Security benefits. The pregnant woman is tax-dependent on her grandmother.
Family size: Two – the pregnant woman and her unborn child
Family income: \$475 a month

Note: The grandmother's income is not counted because only income of an applicant, an applicant's spouse, or an applicant's parents would be considered. The applicant's parents' income is not included because the applicant doesn't live with her parents. The applicant's earned income is counted, but the \$150 the applicant receives from her parents is not counted because cash contributions are excluded from the income calculation.

- B. A married 25-year-old pregnant woman is paid \$615 per month from her job; her spouse is paid \$840 per month from his job. The woman also receives \$150 per month child support from her ex-spouse for their 3-year-old son. She, her son, and her spouse live with her father-in-law; her father-in-law receives \$600 per month in Department of Veterans Affairs (VA) benefits. The pregnant woman files taxes jointly with her husband.

Family size: Four – the pregnant woman, her spouse, her first child, and the unborn child

Family income: \$1,455 a month (\$615 + \$840)

Note: Only the applicant's income is counted. The boyfriend's income is not counted because they are not married and do not file taxes jointly. Child support is excluded from the calculation. The father-in-law's income is not counted because only income of an applicant, an applicant's spouse, or an applicant's parents is considered (and because VA benefits are excluded).

- C. A 22-year-old unmarried pregnant woman lives with her boyfriend (who is the father of her unborn child) and his child from a previous relationship. The boyfriend makes \$1,895 per month from his job and receives \$300 per month from his ex-girlfriend for the support of their child. The pregnant woman makes \$600 per month from her part-time job. The couple files taxes separately, and the woman does not claim her boyfriend's child on her taxes.

Family size: Two – the pregnant woman and the unborn child

Family income: \$600 a month

Note: Only the applicant's income is counted. The boyfriend's income is not counted because they are not married and do not file taxes jointly. Child support is excluded from the calculation.

- D. A 17-year-old married pregnant woman lives with her husband, her mother, and her younger sister. Her husband makes \$1,000 per month from his job; her mother makes \$1,100 per month from her job and receives \$150 per month in child support for the pregnant woman's younger sister. The pregnant woman doesn't have any income. The pregnant woman files taxes with her husband.

Family size: Three – the pregnant woman, her husband, and her unborn child

Family income: \$1,000 a month

Note: Because the pregnant woman is married and files taxes with her husband, her mother's income is not counted. Child support is excluded from the calculation.

- E. A pregnant woman is single with two children. Her monthly income from her employment is \$1,200. Her elderly aunt lives with her and receives \$550 a month from Social Security. The pregnant woman is not tax-dependent on her aunt.

Family size: Four – the pregnant woman, her unborn child, and her two children

Family income: \$1,200 a month

Note: The aunt's income would not be counted because only income of an applicant, an applicant's spouse, or an applicant's parents is considered.

- F. A pregnant woman is single with a 16-year-old son. The only income is her son's child support of \$1,000 per month and the \$150 per month her son makes from a part-time job.

Family size: Three – the pregnant woman, her son, and her unborn child

Family income: \$0.00

Note: Income from child support does not count. Income from household members under age 19, other than the applicant or spouse, is not included in the calculation.

Completing the Presumptive Eligibility Member Application

The QP uses the Portal to verify that an individual does not currently have IHCP coverage and then to submit an application for the individual.

Note: An individual can apply for PE for all members in his or her family. The QP must complete a separate application for each individual for whom PE coverage is being sought.

The following is a step-by-step process for the PE applicant enrollment process.

1. Log in to the [Provider Healthcare Portal](#), accessible from the home page at [in.gov/medicaid/providers](#).
2. Select the **Eligibility** tab from the menu bar.
3. In the *Eligibility Verification Request* panel, enter the applicant's Social Security number (SSN) and birth date or the applicant's last name, first name, and birth date. (If the applicant has a Member ID related to previous coverage, it may be used in place of the preceding fields.)

The Effective From field defaults to the current date.

Figure 5 – Eligibility Verification Request Panel

4. Click **Submit**.
5. After the system confirms that no coverage exists for the individual, click the appropriate button:
 - **PE Application**
 - **PE Application for Pregnant Women**

Note: The system displays these buttons only for individuals with no current coverage or with only Medical Review Team (MRT) or Preadmission Screening and Resident Review (PASRR) coverage. (MRT and PASRR are the only benefit plans that do not preclude PE enrollment.)

*In addition, the system displays these buttons only for QPs certified to submit PE or PEPW applications (see the [Enrolling as a Qualified Provider](#) section). QPs that are certified for PEPW **only** will see only the “PE Application for Pregnant Women” button. QPs certified for PE will see the “PE Application” button, which can be used to submit **all** PE applications, including applications for pregnant women and, if the QP is a hospital (specialty 010 or 011), for inmates without current coverage. There is no separate QP certification for PE for Inmates, but the process is limited to PE QPs in those two specialties.*

Figure 6 – PE Application Button

*Note: For individuals who **do** have current coverage, hospital QPs (specialty 010 or 011) will see the “PE Application for Inmate” button. This application can be used **only** for individuals who meet the requirements described in the [Special Rules Regarding Presumptive Eligibility for Inmates](#) section.*

PE Application for Inmate

6. Complete the *PE Member Application* by entering information provided by the individual applying for PE. See [Table 3](#) for a list of information needed and corresponding instructions. (Some fields do not appear on all three applications, or may appear in a slightly different order depending on the type of application.)

Note: Information on the PE application is self-attested by the individual. QPs may not ask for verification documents when completing a PE application. Proof of income, pregnancy, residency, citizenship, and any other documents are not required. The individual responding to the questions must provide his or her name and email address in the appropriate fields.

Table 3 – Presumptive Eligibility Member Application Descriptions

Field (*Required)	Description
*First Name	Enter the applicant's first name. Up to 13 characters, alphanumeric. Allows space, dash, and period.
M.I.	Enter the applicant's middle initial. Allows one character, alphanumeric.
*Last Name	Enter the applicant's last name. Up to 15 digits, alphanumeric. Allows space, dash, and period.
Suffix	Enter suffix if applicable.
*Date of Birth	Enter the applicant's date of birth.
*Home Address	Enter the applicant's home street address. Up to 30 characters, alphanumeric. Allows space, dash, and period.
*(Home) City	Enter home-address city. Up to 15 characters, alphanumeric. Allows space, dash, and period.
*(Home) Postal Code	Enter home-address ZIP Code. Requires five digits.
*(Home) County	Select home-address county from the drop-down list.
Mailing Address	If the applicant's mailing address is different from his or her street address, enter the mailing street address. Up to 30 digits, alphanumeric. Allows space, dash, and period.
(Mailing) City	Enter mailing-address city. Up to 15 digits, alphanumeric. Allows space, dash, and period.
(Mailing) State	Select mailing-address state from the drop-down list.
(Mailing) Postal Code	Enter mailing-address ZIP Code. Requires five digits
Member Email	Enter the applicant's email address.
Home Phone	Enter the applicant's home telephone number. 10 digits, numeric.
Work Phone	Enter the applicant's work telephone number. 10 digits, numeric.
Cell Phone	Enter the applicant's cell phone number. 10 digits, numeric.
Other Phone	Enter any other telephone number for the applicant. 10 digits, numeric.
SSN	Enter the applicant's nine-digit Social Security number (SSN).
Race	Select the applicant's race from the drop-down list options: African American, Asian, Caucasian, Hispanic, Other.
Ethnicity	Select the applicant's ethnicity from the drop-down list options: Hispanic, Non-Hispanic, Other.
*Gender	Select the applicant's gender from the drop-down list options: Male, Female.
Marital Status	Select the applicant's marital status from drop-down list options: Married, Single.

Field (*Required)	Description
*Indiana Resident?	Select Yes or No to indicate whether the applicant lives in Indiana.
*Incarcerated? DOC facility	Select Yes or No to indicate whether the applicant is incarcerated. Incarceration includes a county jail or any type of prison or correctional facility. It excludes home detention and persons on parole. If Yes is selected, select the Department of Corrections (DOC) facility in which the member is incarcerated (<i>PE for Inmates applications only</i>).
*Pregnant?	Select Yes or No to indicate whether the applicant is pregnant.
*Number of People in Family	Enter the applicant's family size. Up to two digits, numeric. Family size is based on the tax household . If the applicant does not file taxes, the household includes any of the following living in the household: <ul style="list-style-type: none"> • Applicant • Applicant's children under age 19 (including unborn child/children if applicant is pregnant) • Applicant's spouse (if taxes are filed jointly with spouse) • Applicant's spouse's children under age 19 (if taxes are filed jointly with spouse) • Applicant's parents (biological, adopted, and step), if applicant is under age 19 and unmarried • Applicant's unmarried siblings (biological, adopted, and step) under age 19, if applicant is under age 19 and unmarried
*U.S. Citizen? Alien Status	Select Yes or No to indicate whether the applicant indicates that he or she is a U.S. citizen. If No is selected, choose one of the following options from the Alien Status drop-down list: <ul style="list-style-type: none"> • Lawful permanent resident immigrant living lawfully in U.S. for 5 years or longer • Lawful permanent resident immigrant living lawfully in U.S. for less than 5 years • Refugee • Individuals granted asylum by immigration office • Deportation withheld by order from an immigration judge • Amerasian from Vietnam • Veteran of U.S. Armed Forces with honorable discharge • No immigration papers (includes persons in the country illegally, persons with visas of any kind, and so forth)

Field (*Required)	Description
*Family Income	<p>Enter the amount of family income, up to six digits, as stated by the applicant.</p> <p>Select Monthly or Annually from the drop-down list to indicate if the amount entered is a monthly or annual income amount.</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p><i>Note: To convert weekly income to monthly income, multiply the weekly amount by 4.3. For example, \$350 per week converts to (\$350 x 4.3) \$1,505 per month. To convert biweekly income, multiply the weekly amount by 2.15.</i></p> </div> <p>In the amount entered in the box, include all income before taxes are deducted (gross income) from the applicant and his or her spouse. If the applicant is under age 19, unmarried, and living with one or more parents, include the income of the applicant and that of his or her parents. Other than the applicant or spouse, do not count income of children under age 19, unless the children are expected to be required to file a federal tax return.</p> <p>Include all the following types of income in the amount entered in the box:</p> <ul style="list-style-type: none"> • Wages/salaries • Tips • Self-employment • Dividends • Interest • Social Security (excluding SSI benefits) • Unemployment compensation • Sick benefits, retirement benefits, or pensions • Rental income
Pending <i>Indiana Application for Health Coverage</i> ?	Select Yes or No to indicate whether the applicant has said that he or she has an <i>Indiana Application for Health Coverage</i> pending.
Health Insurance Coverage (if applicable)?	Select Yes or No to indicate whether the applicant currently has health insurance coverage (excluding Medicare).
Medicare (if applicable)?	Select Yes or No to indicate whether the applicant currently has Medicare coverage.
*In Foster Care in Indiana on 18th birthday?	Select Yes if the applicant was in foster care in Indiana on his or her 18th birthday, under the responsibility of the state of Indiana, and was enrolled in an IHCP program on his or her 18th birthday. Otherwise, select No .
*Do you live with at least one child under 18 years of age and are you the main caretaker?	Select Yes if the applicant lives with at least one child under 18 years old and is the main caretaker of that child. Otherwise, select No .

Figure 7 – PE Member Application

PE Member Application

* Indicates a required field.

Note: This Web Application will generate documents in Adobe Acrobat Portable Document Format (PDF). To view or print these documents, you must have the free [Adobe Acrobat Reader](#) installed.

Identifying Information

*First Name M.I. *Last Name

*Date of Birth *Confirm Date of Birth Suffix

Address Information

Home Address

*Address

*City State *Postal Code *County

Mailing Address (if different than home address)

Address

City State Postal Code

Member Email

Phone Numbers

Home Phone Other Phone

Other Information

SSN

Race

Ethnicity

*Gender

Marital Status

*Indiana Resident? ?

*Incarcerated? ?

*Pregnant?

*Number of people in family ?

*U.S. Citizen? ?

*Family Income ?

Pending Indiana application for health coverage? ?

Health Insurance Coverage (if applicable)? ?

Medicare (if applicable)? ?

*In Foster Care in Indiana on 18th birthday? ?

*Do you live with at least one child under 18 years of age and are you the main caretaker? ?

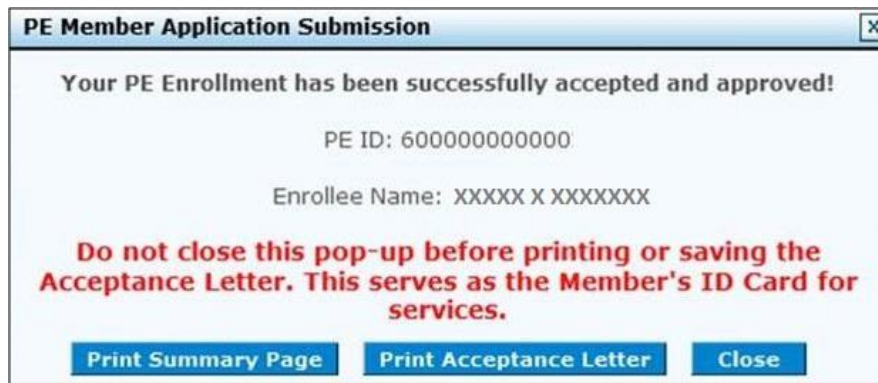
Disclaimer

☐ I attest that I have been trained to process applications for Presumptive Eligibility (PE).

Submit Application

7. Select the box in the Disclaimer section at the bottom of the application to attest that you have been trained to process applications for PE.
8. Review the information entered with the applicant to confirm that it is accurate.
9. Click **Submit Application**.
10. The *PE Member Application Submission* window appears, indicating whether the PE enrollment was successfully accepted and approved and, if so, showing the assigned PE ID.

Figure 8 – PE Member Application Submission Window



Note: The PE ID begins with the digit 6, except in cases where the applicant is found to have had previous IHCP coverage, in which case, the applicant's originally assigned IHCP Member ID becomes his or her PE ID.

11. Click **Print Acceptance Letter** to print the PE determination notice for approved applicants.

QPs must ensure that the presumptive eligibility determination notice (acceptance letter or denial letter) prints successfully before clicking **Close**.

12. Click **Print Summary Page** to print a copy of the application for your records.

Note: The PEPW application does not currently include an option to print a summary page.

13. Click **Close**.

14. Give a copy of the determination notice to the applicant. The acceptance letter serves as the PE member identification during the PE coverage period.

15. Review PE coverage information with the member and provide guidance to help ensure that he or she submits the full *Indiana Application for Health Coverage* by the end of the month following the month in which the PE determination was made. As explained in the acceptance letter, the individual may complete the *Indiana Application for Health Coverage* in one of the following ways:

- Online at the [FSSA Benefits Portal](https://fssabenefits.in.gov) at fssabenefits.in.gov
- In person at a local [FSSA DFR office](#) or with the provider where the presumptively eligible was determined
- By telephone at 1-800-403-0864

Presumptive Eligibility Coverage

Members determined to be presumptively eligible for coverage through the PE process are assigned to the appropriate benefit plan based on their aid category, as shown in Table 4. Incarcerated individuals determined to be presumptively eligible through the PE for Inmates process are an exception; these members are assigned to the Medicaid Inpatient Hospital Services Only benefit plan, regardless of aid category, as described in the [Special Rules Regarding Presumptive Eligibility for Inmates](#) section.

Table 4 – PE Benefit Plan Assignment Based on Aid Category

PE Aid Category	PE Benefit Plan
Infants	Presumptive Eligibility – Package A Standard Plan
Children	
Parents/Caretakers	
Former Foster Care Children	
Adults	Presumptive Eligibility – Adult
Pregnant Women	Presumptive Eligibility for Pregnant Women
Family Planning	Presumptive Eligibility Family Planning Services Only

All PE benefit plans are reimbursed through the fee-for-service (FFS) delivery system. During the presumptive eligibility period, the PE member is able to receive services covered within his or her benefit plan from any IHCP-enrolled provider.

Presumptive eligibility coverage begins on the date that the PE determination is made. Services delivered prior to this date are not covered.

If the PE member does not submit a completed *Indiana Application for Health Coverage* application, the PE period lasts until the end of the month following the month in which the presumptive eligibility determination was made. For example, if the presumptive eligibility determination was made on March 10, the individual would retain PE coverage until April 30 if no *Indiana Application for Health Coverage* is submitted.

If the individual files an *Indiana Application for Health Coverage* within the allotted time frame, his or her presumptive eligibility period lasts until an official eligibility determination (approval or denial) from the FSSA DFR has been made.

Note: PE members who have been determined to be conditionally eligible for Healthy Indiana Plan (HIP) coverage retain their PE coverage after their HIP determination to allow time for them to make their Personal Wellness and Responsibility (POWER) Account contribution. This extension of the PE period allows these members to avoid a gap in coverage, as long as they meet required application and payment deadlines.

Individuals cannot reapply for presumptive eligibility within 12 months (or, for PEPW, during the same pregnancy). Therefore, it is imperative that the QP informs the individual that he or she must submit a full *Indiana Application for Health Coverage* before the temporary eligibility period ends – and provides information on how the individual can do so.

Presumptive Eligibility – Package A Standard Plan

Presumptive Eligibility – Package A Standard Plan (for Infants, Children, Parents/Caretakers, and Former Foster Care Children aid categories) offers full Medicaid benefits, including all covered services available under Package A – Standard Plan).

Presumptive Eligibility – Adult

The Presumptive Eligibility – Adult (PE Adult) benefit plan includes all covered services available under the *HIP Basic* benefit plan. See the [Healthy Indiana Plan](#) module for details about *HIP Basic* coverage; note, however, that PE Adult benefits are delivered on a fee-for-service basis rather than through a managed care entity (MCE).

The copayment requirements for PE Adult are also the same as those for *HIP Basic*:

- Professional claims (medical/physician): \$4 per rendering provider, per date of service
- Outpatient claims (hospital/facility): \$4 per date of service
- Inpatient claims: \$75 per admission
- Preferred drugs: \$4 per prescription
- Nonpreferred drugs: \$8 per prescription
- Nonemergency ER visit: \$8

Note: Copayments do not apply to pregnant members, American Indian/Alaskan Native members, or members who have met their maximum cost-sharing obligation for the quarter. See the [Member Eligibility and Benefit Coverage](#) module for details.

In addition, the following services are exempt from PE Adult/HIP Basic copayment requirements:

- Preventive care services
- Tobacco cessation drugs
- Family planning services
- Nonpharmacy services provided for an emergency health condition.
(Professional claims must include an emergency indicator at the detail level; outpatient claims must include an emergency diagnosis code; and inpatient claims must have admission type 1 or 5 or be a transfer with an admission source of 4.)

PE Adult members who complete an *Indiana Application for Health Coverage* by the end of the month following the month PE was established, and are determined by the FSSA to be eligible for HIP, will retain their PE coverage for up to 60 days, provided application timelines are met. This time frame allows members to make a POWER Account contribution and gain full HIP eligibility without a gap in coverage. If the member is approved for HIP and his or her income is less than 100% of the FPL and he or she fails to make a POWER Account contribution, he or she will be enrolled in *HIP Basic* coverage. A member with an income greater than 100% of the FPL who fails to make a POWER Account contribution within 60 days will lose coverage.

PE Adult members who meet Fast Track criteria can make a \$10 prepayment when they submit the *Indiana Application for Health Coverage*. If the member is approved for HIP coverage and a Fast Track payment was made, *HIP Plus* coverage will start beginning the first of the month following the prepayment.

Presumptive Eligibility for Pregnant Women

The Presumptive Eligibility for Pregnant Women benefit plan (for the Pregnant Women aid category) is limited to ambulatory prenatal care services only, including the following:

- Doctor visits for prenatal care
- Prescriptions related to pregnancy
- Prenatal lab work
- Transportation for prenatal or emergency-related care

PEPW does **not** cover the following, although these services *may* be covered retroactively if the woman is later determined to be fully eligible for IHCP benefits:

- Hospice
- Long-term care
- Inpatient care
- Labor and delivery services
- Abortion services
- Sterilization and hysterectomy services
- Postpartum services
- Services unrelated to pregnancy or birth outcome

Note: Inpatient care is not covered for prenatal-related services.

When billing for services provided to PEPW members, it is important to use the appropriate pregnancy-related diagnosis and pregnancy indicator on the claim. For a list of covered diagnosis codes, see *Presumptive Eligibility for Pregnant Women Codes*, accessible from the [Code Sets](https://in.gov/medicaid/providers) page at in.gov/medicaid/providers.

After the DFR makes a determination on the full application, the member will be assigned to the appropriate program based on income and other eligibility criteria:

- Pregnant women at or below 138% of the FPL and eligible for the HIP program will be enrolled in the **HIP Maternity** benefit plan with a HIP MCE.
- Pregnant women above 138% of the FPL and eligible for IHCP services will be enrolled in **Package A – Standard Plan** with a Hoosier Healthwise MCE.

Pregnant applicants who are approved for enrollment in HIP or Hoosier Healthwise may also be determined eligible for retroactive coverage for up to 3 months prior to their IHCP application date. This retroactive coverage is provided through the FFS delivery system. During the retroactive time period, the IHCP EVS will identify the member's coverage as *Package A – Standard Plan* without an assigned MCE. This retroactive coverage will override the existing PE coverage and includes benefits beyond the pregnancy-related services covered under the PEPW benefit plan.

Note: If a woman's pregnancy ends at any time during her presumptive eligibility coverage period, her PEPW coverage continues until it would normally end.

Women are eligible for PEPW coverage once per pregnancy. If a PEPW member miscarries and becomes pregnant again during the 9 months following her original pregnancy, the QP should contact his or her IHCP Provider Relations representative to request a new PEPW period. To identify your Provider Relations field consultant, see the [Provider Relations Field Consultants](https://in.gov/medicaid/providers) page at in.gov/medicaid/providers.

Presumptive Eligibility Family Planning Services Only

The Presumptive Eligibility Family Planning Services Only benefit plan is limited to the services defined under the Family Planning Eligibility Program benefit plan, including the following:

- Family planning visits, including health education and counseling necessary to understand and make informed choices about contraceptive methods
- Limited health history and physical exams
- Laboratory tests (if medically indicated as part of the decision-making process regarding contraceptive methods)

- Cytology (Pap tests) and cervical cancer screening, including high-risk human papillomavirus (HPV) DNA testing, within the parameters described in the [Obstetrical and Gynecological Services](#) module
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider
- Food and Drug Administration (FDA)-approved contraceptive drugs, devices, and supplies, including emergency contraceptives
- Initial diagnosis of sexually transmitted diseases (STDs) and sexually transmitted infections (STIs), if medically indicated, including the provision of FDA-approved anti-infective agents
- Screening, testing, counseling, and referral of members at risk for human immunodeficiency virus (HIV) within the parameters described in the [Laboratory Services](#) module
- Tubal ligations
- Hysteroscopy sterilization with an implant device (Essure)
- Vasectomies

For a list of covered codes, see *Family Planning Eligibility Program Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

Member Identification and Eligibility Verification

Members who are found eligible through the PE process use the acceptance letter provided by the enrolling QP to serve as proof of coverage during their presumptive eligibility period. These members do not receive IHCP member identification cards. The letter clearly indicates the dates the member's presumptive eligibility period begins and ends, and the member's PE ID.

PE coverage is reflected in the IHCP EVS and FFS pharmacy systems within 24 hours of the initial determination. The original presumptive eligibility acceptance letter is sufficient to validate temporary coverage, even if the member is not yet listed in the appropriate system.

Individuals are allowed only one presumptive eligibility coverage period per rolling 12 months or pregnancy, whichever is applicable. As with all IHCP members, providers serving individuals who have previously been determined presumptively eligible must verify the individual's eligibility on each date of service. The EVS options (Portal, IVR system, and 270/271 transaction) accept the PE ID in place of the IHCP Member ID.

If the FSSA approves an individual for IHCP eligibility, his or her coverage changes from the PE benefit plan assigned during the PE process to the appropriate IHCP benefit plan. He or she also receives a member identification card with his or her Member ID number.

Inpatient Admission and PE Eligibility

For presumptive eligibility benefit plans that include inpatient hospital coverage, whether or not any portion of the inpatient stay will be covered when the admission date is before the PE start date depends on how the service is reimbursed:

- If the hospital admission date is before the PE start date and the inpatient service is reimbursed using the diagnosis-related group (DRG) methodology, no portion of that member's inpatient stay will be considered a PE-covered service.
- If the hospital admission date is before the PE start date and the inpatient service is reimbursed on a level-of-care (LOC) per diem basis, dates of service on or after the member's PE start date will be covered. Dates of service before the member's PE start date are not covered.

Special Rules Regarding Presumptive Eligibility for Inmates

Certain incarcerated individuals can receive limited Medicaid coverage through the PE for Inmates process. This process allows hospitals that are PE QPs to enroll eligible individuals into the IHCP for temporary coverage of authorized inpatient hospitalization services. The following sections describe the specific rules and restrictions regarding the PE for Inmates process.

Note: Only acute care hospital and freestanding psychiatric hospital (provider type 01, specialty 010 or 011) QPs are eligible to enroll members through the PE for Inmates process. This process is not available to the other PE qualified provider types.

Individuals Eligible for PE for Inmates

The PE for Inmates process is available to individuals who meet the following requirements:

- Be an inmate from an Indiana Department of Correction (IDOC) facility or county jail operating under a memorandum of understanding (MOU) or contract with the Indiana FSSA
- Not be on house arrest
- Not be pregnant or admitted for labor and delivery
- Be under the age of 65
- Be admitted for inpatient hospitalization
- Meet all standard PE requirements (see the [Presumptive Eligibility Applicant Requirements](#) section), except requirements pertaining to incarceration, current IHCP coverage, and current or past PE coverage

Note: Individuals from various aid categories may be found presumptively eligible under the PE for Inmates process. All previously indicated requirements specific to the aid category – including income requirements – continue to apply under PE for Inmates.

Specific Application Instructions for PE for Inmates

When completing the PE application for incarcerated individuals, hospital PE QPs should:

- Use the correctional facility's address and telephone number as the applicant's home address and telephone number.
- Select **Yes** in the Incarcerated? field. The DOC Facility drop-down menu will appear, listing all eligible correctional facilities. To be on the list, the correctional facility must have a signed MOU or contract with the Indiana FSSA. Select the inmate's correctional facility from the drop-down menu.
- Complete the rest of the application according to normal procedures.

If the incarcerated individual meets all the eligibility requirements, he or she will be enrolled in the Medicaid Inpatient Hospital Services Only benefit plan.

Services Covered under PE for Inmates

Individuals enrolled through the PE for Inmates process are assigned to the Medicaid Inpatient Hospital Services Only benefit plan, which provides coverage for inpatient services only.

If an inmate's admission results from an emergency department visit, the physician services performed in the emergency department prior to admission can be reimbursed. In all other cases, services can be reimbursed only if they are provided between inpatient admission and discharge. The following are examples of services that may be covered for inmates hospitalized for at least 24 hours:

- Medically necessary physician services provided during the inpatient stay
- Medically necessary hospital services provided during the inpatient stay
- Medically necessary medications provided during the inpatient stay
- Medically necessary durable medical equipment (DME) provided during the inpatient stay

Any service provided on an outpatient basis, before inpatient admission or after discharge, will not be reimbursed. The following are examples of services that are not covered:

- Transportation that occurs before admission or after discharge
- Services provided in the emergency department if the visit does not result in an inpatient admission
- Medications or DME that are provided before inpatient admission or after discharge

For special billing instructions related to the Medicaid Inpatient Hospital Services Only benefit plan, see the [Claim Submission and Processing](#) module.

Coverage Period for PE for Inmates

Medicaid Inpatient Hospital Services Only coverage is effective for up to 1 year or until the offender is released, whichever is sooner. If an individual remains incarcerated beyond 12 months, he or she may reapply for coverage through the PE for Inmates process.

Individuals enrolled through the PE for Inmates process must also complete an *Indiana Application for Health Coverage*. Upon release, an individual is allowed to use the standard PE process, without regard to any PE for Inmates eligibility obtained within the past 12 months.

Presumptive Eligibility Claim Submission

Providers serving individuals who have been determined presumptively eligible must verify the individual's eligibility on each date of service. Additionally, QPs should verify whether the individual has other health insurance before submitting claims for PE services, because Medicaid is always the payer of last resort.

Claims for PE services are submitted with the member's PE ID, which starts with a "6" (except in cases where an IHCP Member ID already existed for that individual due to previous coverage). If a PE member is later officially approved for coverage under the IHCP, QPs should then submit claims using the newly assigned Member ID.

QPs should submit claims compliant with applicable program standards. Claims for services rendered during the presumptive eligibility period should be submitted to DXC, as described in the [Claim Submission and Processing](#) module.

QPs are reimbursed at regular IHCP FFS rates for services rendered during the PE period. Reimbursement for covered services rendered during the PE period is allowable even if the PE member ultimately fails to complete the *Indiana Application for Health Coverage* application, or if the FSSA determines the individual to be ineligible for the IHCP.

For PE Adult members, copayments will be applied (see the [Presumptive Eligibility – Adult](#) section).